MINUTES
MEDICAL EDUCATION INTERIM COMMITTEE

November 12, 2008
9:00 a.m. to 4:00 p.m.
Clear Waters Room, Len B. Jordan Building
650 West State Street, Boise, Idaho

Chairman Bob Geddes; Co-Chair Representative Maxine Bell

Chairman Bob Geddes called the meeting to order at 9:05 a.m. All Committee members and ex-officio members were present.

NOTE: All copies of presentations, reference materials, and handouts will be on file at the Legislative Services Office (LSO).

Dr. Dennis Stevens, Ph.D., M.D., Chief, Infectious Diseases Section and Associate Chief of Staff, Research and Development Services, Boise Veterans Administration Center (VA)
Dr. Stevens explained that the VA has three primary missions. The primary mission is excellent care for veterans. There are two secondary goals: education and research, both are required for a medical school. There has been a tremendous increase in the demand for care within the VA growing from 9,000 patients in 1997 to 19,000 ten years later. There are 180,000 outpatient visits annually. The Boise VA made a transition with its mission as a result of its affiliation with the University of Washington (UW) WWAMI program and they serve as a site for junior and senior medical students through that program. They have a transitional year internship and have trained over 200 primary care internal medicine residents; 51 stayed in Idaho. The VA collaborates with the Family Practice Residency of Idaho where first year residents spend a block of time at the VA. The VA has not received any remuneration for costs of these programs. The VA has strong academic affiliations with other institutions in the state: University of Idaho (UI), and the School of Pharmacy at Idaho State University (ISU). There is a need to improve relationships with other institutions of higher learning in the state to develop a biomedical research institute located at the VA.

Dr. Stevens distributed a handout (on file at LSO), *The Strategic Plan to Enhance State, Private and Veterans Affairs Medical Center Biomedical Research in Idaho* which outlined the Goals, Elements, Action Plan, Funding, and Business Plan. The VA has approval for a $7.0 million building from the Department of Veterans Affairs Minor Construction Program that was approved in 2007 to be constructed in FY 2010. Further federal support would be: basic research science labs, administrative support, research faculty (7 MDs and 6 PhDs), utilities, telephones, security, equipment, an animal research facility, and research associates/technicians.

As part of the funding plan, a request for support would come to the state for six PhD research investigators, two from each of Idaho's public universities: Boise State University (BSU), ISU, and UI; stipends, tuition and health care costs for six graduate students per year; stipends for three post-doctoral fellowships; and salary for a secretary/education coordinator/grant writer. The proposed State support would come to $975,000. The universities and State Board of Education (SBOE) has been involved in this proposal and has shown their support. This partnership between Idaho's major academic institutions and the VA would provide the opportunity to capture multi-millions of state, federal and private research dollars which would significantly improve the biomedical research infrastructure in the state and improve opportunities for Idaho scientists, provide state-of-art training for Idaho students, and facilitate

recruitment of scientists into the state which would yield significant long-term economic benefits to Idaho and would position Idaho to be a nationally recognized leader in biomedical research.

President Terrell asked for the definition of an investigator. **Dr. Stevens** stated that an investigator is someone who submits grants to federally funded agencies like the VA to get research money and does investigative experiments to answer questions. The general subject matter of the biomedical research institute would relate to important human health care issues.

Co-Chair Bell stated that federal support looks firm and ongoing and questioned how this project would go forward if the proposed state support is less that projected. **Dr. Stevens** said that nothing would happen. The project is not contingent upon state funding – it has been approved and will go ahead. The VA will be able to provide space and equipment, but really good research people are needed and this would be a relatively small investment to provide funds to get quality people to join existing faculty for a quality research operation. **Co-Chair Bell** followed up by asking how research fits in with producing a medical doctor. **Dr. Stevens** said it provides the opportunity for medical doctors to do research and provides teachers who are investigators and researchers to keep up on the latest developments in biomedical issues in order to be able to teach medical students. The quality of medical teaching increases.

Senator Cameron asked if past graduate students of these universities had been considered for those positions. **Dr. Stevens** stated the VA has hired past graduates and would continue to consider them as positions become available. **Senator Cameron** inquired if the funding would be necessary if those students were used. **Dr. Stevens** said the VA pays students stipends, and some of that comes out of research money that goes to UI. Until the student transitions and can get his/her own research funding, their careers are subsidized.

Chairman Geddes inquired, in just the normal operations of the VA and looking at the proposal with additional positions, what has been Dr. Steven's experience in recruiting those doctors and bringing that staff on-line. **Dr. Stevens** answered that recruiting to Idaho is difficult from the large medical schools but there are good things in Idaho compared to larger metropolitan areas and Idaho would look very good, especially with a stable salary. **Chairman Geddes** asked if the VA was fully staffed. **Dr. Stevens** stated that it was since it received some extra funding this year due to the expansion. In general, across the US, people want to do the right thing for veterans, so funding is fairly stable.

Senator Cameron asked what was meant by the approval of the $7.0 million. Has it already reached congressional approval, been appropriated and the VA has it in hand or is it on someone's budget request? **Dr. Stevens** responded that it was beyond budget request. It has been approved by the VA central office. The VA is expecting to have funds in hand soon.

Paul Ramsey, M.D., Chief Executive Officer of UW Medicine and Dean of School of Medicine, UA. Assisted by: Suzanne Allen, M.D., M. P. H. , Asst. Dean for Regional Affairs & Rural Health, UW Medical School and Andrew Turner, Ph.D., Director, UI and WSU, WWAMI. **Dean Ramsey** has been the Dean of the School of Medicine for nearly 12 years and a part of the WWAMI program for 31 years. **Dean Ramsey** provided a history of the cost effective, high quality platform for medical education that exists in the WWAMI program, the current status of WWAMI and was here to discuss the future. WWAMI is responding to the nation's and Idaho's need for a professional workforce pipeline.

WWAMI is recognized internationally as a benchmark program of a distributive model of

community-based medical education. That status has been in place for the last 15-20 years. **Dean Ramsey** discussed the founding goals from 1971 to 2008. WWAMI has grown from a four-year medical education program to a program that includes a number of activities that relate to preparing a health professional workforce to work on the pipeline. These activities are not technically part of WWAMI in the sense they are not funded as WWAMI. They are funded by the WWAMI program overall through grants, private gifts, etc. and not by individual states. There has also been growth in the graduate medical education programs by attracting students (K-12 and undergraduates) to a health science career and after medical school, to residency and fellowship training.

Years one, three and four medical school years can now be completed in Idaho. Year two, the organ systems portion of the training, is conducted in Seattle. There are residencies throughout the state of Idaho under the WWAMI model.

The WWAMI program is unique in our country and there have been inquiries from other countries, most recently China, for this efficient, high quality, cost effective model. For over 35 years, five states have worked together to build this program to deal with health care workforce challenges. The WWAMI program has the best matriculation rate in the country. **Dean Ramsey** presented a comparison of the WWAMI tuition to the public and private sectors. The resident student tuition rate is $17,425 (Academic year 2007-2008 tuition), which is competitive for access to public education and aligns with one of the founding goals. Although the total student debt is low compared to public and private debt, it is still very high. A $100,000 debt is a large debt when the career is in an underserved area where compensation is less than that of a sub specialty in an urban area. The Dean provided other comparisons with national results in producing a health care professional and the WWAMI program, and in all cases WWAMI was more cost effective for a quality education. In an economic impact study by the UI College of Business & Economics, it was found that Idaho WWAMI generates over $5.00 of economic contributions for every state dollar of funding received compared to the national medical school average of $2.30.

The return rate is an important statistic. The Idaho resident return rate is 50% versus the national return rate of 39%. Including Idaho and Non-Idaho WWAMI graduates who set up practice in Idaho gives Idaho a return on investment of 75%. There is a decline in interest for primary care, but WWAMI's focus on the underserved rural areas and focus on primary care has resulted in 48% of the graduates entering the primary care field (10% greater than the national average of 38%). In addition to the medical student program, WWAMI's family medicine residency programs are among the best in the country. Idaho has 19 residency seats in Boise, Caldwell, Magic Valley and Pocatello. There have been 101 Idaho graduates through 2004 with 34.5% practicing in medically underserved communities.

Medical schools bring economic benefit to the state in which they are located via the health care enterprise and specifically those that attract dollars from the National Institutes of Health. The WWAMI faculty at UI has brought in $11.0 million annually to Idaho (5 year average).

WWAMI and the UI would like to work with Idaho to build on this platform, to develop a proposal to expand:

- From 20 to 40 Idaho resident students per year.
- Create a four year WWAMI Idaho medical education program.
- Begin planning to establish a second-year medical education program in Idaho.
- Expand the 3rd and 4th year network of community clinical training sites.
- Build on existing collaborative efforts to create a statewide GME approach to expand

residencies.

- Build on existing collaborative efforts in biomedical research.

Dean Ramsey expounded on the requirements to establish a 2nd year quality program in Idaho.

The first step in 2009 would be to expand the WWAMI Regional Office in Boise in conjunction with the UI to allow for GME planning and development in Idaho, and to create an Idaho legislative proposal regarding this initiative with the charge to:

- Identify opportunities for additional GME in Idaho and build upon existing programs shared between UWSOM and the state of Idaho.
- Strengthen working relationships with hospitals, state agencies and organized medicine to prioritize workforce needs and planning additional residency programs.
- Create an advisory group to oversee planning process.

Chairman Geddes commented on the number of emails he received that were extremely complimentary of the program, although some did express some feelings of guilt about being accepted into the program when many others were not. The Chair called for questions.

Senator Cameron commented on WWAMI as a "distributive model" and all the programs within the WWAMI educational continuum. **Senator Cameron requested that Dean Ramsey send him information on those programs; what they are, how they benefit Idahoans, how they are being used in Idaho.**

Senator Cameron also asked the Dean to elaborate on 3 out of 4 medical school years being completed in Idaho. **Dean Ramsey** said students can complete years 1, 3, and 4 in Idaho, although not all choose to do so. In those instances that an Idaho student does not chose to do their 3rd and/or 4th year in Idaho, students from one of the other WWAMIstates can fill that spot in the Idaho Track. WWAMI was the first, and still is really the only one of the big research programs that has a distributive model meaning that the education occurs outside the walls of the "big teaching hospital." WWAMI has been a distributive model and partners with multiple states, universities, and with the communities and the various associations within the state. Private hospitals are used where the primary focus is on the practice of medicine and approaches are used to build student teaching into that setting.

Senator Cameron referred to the UI economic impact study and questioned the validity of the numbers. The numbers indicate about $2.5 million in taxes annually. The annual appropriation is about $3.4 million so that amounts to every $3.40 put in, there is a $2.50 return. Something is missing in the equation. **Dean Ramsey** said that if just the taxes were considered, that would be true. This type of calculation builds into the return a combination of tax dollars and other dollars, for example NIH dollars that are spent in the state. **Senator Cameron** said that if the appropriation of $3.4 million was 5 to 1 equals approximately $16.0 and if the grant dollars are going to be added in, then the appropriations to the UI for faculty to maintain the grants should be added in as well. There is just a problem with the math. **Dean Ramsey will get back to Senator Cameron with information about how the calculations were made.**

Speaker Newcomb found it interesting that NIH money comes back to WWAMI and commented about the U.S. senators from the five WWAMI states working together. He asked whether the ten senators always been unified and supportive when it comes to WWAMI and NIH funding? **Dean Ramsey** stated that he has been in his position for nearly 12 years and during that time, the answer would be yes.

Mrs. Thilo questioned the statistic regarding the match rate (95% of the time the graduates are matched with residency programs), and how it would that compare to national statistics. **Dean Ramsey** said that there are not good national statistics for comparisons. The 95% success rate is a great marker of the program that the graduates have their choice of jobs.

Representative Rusche asked if the Spokane program was similar to the Moscow program where it is one year and then to Seattle for the second year or is that building into a four year program. **Dean Ramsey** replied that the Spokane program is very similar to the current program in Idaho. It has created a first year site at WSU in Spokane, an affiliated partner of WWAMI. Spokane is trying to build on the success Idaho has had over the last ten years to have very high quality third and fourth year courses available in Spokane and Eastern Washington similar to those courses being available across the state of Idaho. It is conceivable that there could be a second year program in Spokane as well.

Representative Rusche inquired about the status of increasing Idaho's WWAMI seats to 40 per year and whether they would be on location at UI or multiple locations. **Dean Ramsey** stated that the expansion proposal was not that far along. The planning that would begin for the four year model would start as soon as the Legislature asked WWAMI to begin and they would be prepared to fund that planning. As part of that planning, in the relatively near future, WWAMI could address the question as to how far could they get with the 40 seats with the focus on the first year at Moscow and the current third and fourth year at teaching sites around the state as well as in Boise. It is possible an additional site would be added, but that question could not be answered right now.

President Vailas asked for clarification about what the state subsidized per student plus what the student has to pay, that total calculation per student is way off the national average. "How is that an economic benefit?" The tuition of $17,000 per student is low, but the point is, it is subsidized by other sources. If that additional subsidized amount was factored in, it would be pretty expensive, close to over $100,000 per student. **Dean Ramsey** said the number for the country is the number calculated by the Association of American Medical Colleges for all schools and is probably low since it was calculated using 2005, 2006, and 2007 data. Adding the $63,000 and the $17,000 together is still lower than the national average and the WWAMI program can continue to maintain the total cost at a substantially lower cost per student /year.

[Correction: For 2008-2009, State support is $44,500 and tuition is $19,100 for a total per student cost of $63,600. – Editor]

President Vailas pursued the issue that if one looked at the national statistic of a 39% return of students back to Idaho, the absolute numbers of educating medical students if there was a medical school, then the numbers would be much higher than 20 for the same cost. The point is, if there was the appropriate infrastructure for the distributive model, there could be three times the number of students for the same costs. **Dean Ramsey** based his comments on his 35 years of experience. He has not seen in our country or in the world, a more cost effective platform for medical education than WWAMI. The return rates being referred to are wonderful rates for a distributive model at a real return rate for WWAMI of 75%. That is what Idaho has seen in terms of a WWAMI practitioner remaining in Idaho.

President Vailas stated that medical schools or health science centers have many synergies and degrees and economies of scales that promote research and degree programs that are interconnected with the production of a M.D. or resident. It is a surprise that WWAMI has not taken advantage of these synergies in the execution of education, research, and health

professional programs. There are other universities in the state of Idaho who have enormous portfolios of these degree programs. "Was that by design and how is that going to be built into the future of the WWAMI plan." **Dean Ramsey** responded that it does present an opportunity with the WWAMI platform. There is a partnership with UI but there are many other opportunities with ISU and BSU and other settings in Idaho on other graduate degrees that are critical for the health care workforce pipeline. Research also has a good platform to build upon in Idaho.

President Vailas commented on the value of a medical school and asked if an opportunity arose to afford to enter that competitive arena, what would be the loss of funds for a state not to have the ability to compete given NIH is the largest public funding of research? **Dean Ramsey** responded that related to the direction of biomedical research and especially translational science, which ultimately means how medicine can evolve to be more prevention oriented and less acute care oriented. This is extremely difficult and very expensive and NIH has taken the position that this needs to be done in partnership across multiple universities. Idaho is now part of what is referred to as the Institute of Translational Health Sciences that is partnering with several universities to create the infrastructure to deliver on doing this research. The extreme expense arises out of the evolving electronic age of medical records; data needs to be collected to be analyzed in a cost effective way which can happen when there are university partnerships across state lines. For the future, the big research grants which support the infrastructure to do this research are depending on multiple medical schools coming together and that is what WWAMI is – five universities.

President Daley-Laursen referred to the efforts that are needed to grow a second year program. Looking at all the players and Idaho's evolving medical education research program, tying it to health education research, and having it serve Idaho's perceived needs for the future – it is an evolutionary process. There is a great concern that Idaho has an extremely high quality program, world renown, and we want to evolve that now to something that will take care of Idaho's needs. He asked if the Dean could expand beyond impressions or perspectives on growing a second year curriculum – how could quality maintained while growing something larger? **Dean Ramsey** explained that the second year is one of the most expensive pieces of medical education to do in a quality way because of the 200+ faculty specialists needed. WWAMI has the advantage of already having a developed curriculum which is cost effective instead of each school developing its own curriculum. If the partnership is pursued, WWAMI would already have one of the greatest curriculums in the country. How to deliver it is another question and that would require innovative methods which would be a new step for WWAMI. Schools have not been successful in using the virtual classroom. There is experience outside the country more than within the country i.e. British Columbia. To be successful, a classroom of 50 needs to be broken down into groups of ten to do this type of teaching to be effective and the learner has to be committed to be involved in problem solving or what is referred to as "problem based learning." Several experts must be involved in the area that is being learned by the student. Speculatively, this could be done in Boise by a virtual approach, bringing specialists from other areas to the teaching table.

Dr. Turner offered a brief two-page summary of the economic impact study that was done by the faculty at the College of Business and Economics at the UI (on file at LSO). Dr. Turner stated that Senator Cameron was correct in his calculations but the report goes into more detail on how the numbers in Dean Ramsey's presentation were derived.

Chairman Geddes stated that UI would provide any information deemed important and necessary and Mr. Freeman will collect that information and get it to Committee members.

Phil Stiffler, Economic Excellence Coordinator, City of Meridian

Mr. Stiffler distributed a handout with statistical data for review but would not go over that information (on file at LSO). **Mr. Stiffler**, speaking on behalf of the Mayor, the Council, and the stakeholders and citizens of Meridian, believes one of the biggest economic engine drivers for the future is in health sciences and technology and medical biosciences research and development. **Mr. Stiffler** posed that the opportunity should be seized and action taken to declare economic excellence to sustain the economic value long term to the benefit all the citizens in the state. Any decisions the Legislature makes regarding allocations and return on investment must be based on that parameter. They should look at what really is the return on investment considering the leveraged assets of the educational institutions in which the state invests in and those other institutions that already exist here. He stated that there is an excitement in what St. Luke's Hospital is doing in research, what St. Al's is doing and what a new complex care hospital means to Meridian and the Treasure Valley. Add to that, the clinical trials the Urology Institute is doing in Meridian. Those are all leveraged assets and opportunities from that economic engine to bring value of the state and citizens. **Mr. Stiffler** read from an opinion editorial from the November 11, 2008 issue of the Idaho Statesman. **Mr. Stiffler** stated that education excellence does bring economic excellence. The thing the Legislature and the SBOE must face is how can the state best leverage its assets, how can it get the best return on investment. He urged the committee to not look at this short term, but rather long term. He continued that when inquiries are made by a medical technology company or research entities that are interested in locating in the Treasure Valley, the absence of a medical school within the state does not impress them a lot. He emphasized that response does not reflect poorly on WWAMI, because it is a quality program. His point was that WWAMI is not part of our state, it is not here, it is not part of us in its own way. There is a tremendous medical community here that can offer so much. Also, the numbers and economic data that have been distributed today must be viewed carefully to determine the return on investment to the citizens and stakeholders of this state for long term.

Dr. Joseph Williams, Idaho Urologic Institute, Boise/Meridian

Dr. Williams stated that he is an urologist not a statistician so his presentation will be from the viewpoint of a physician who has worked in Idaho for ten years. Dr. Williams trained at the National Naval Medical Center which is a classic example of the distributive model of medical education. His undergraduate medical education was done at University of Arkansas, another classical example of the distributive model. Arkansas may be an example of what Idaho may want to emulate if Idaho chooses to have a medical school due to the similarities within a rural based state. As an urologist, **Dr. Williams** takes care of cancer patients and the elderly (35% Medicare). Most patients have these problems as their main issue so the urologist is oftentimes burdened with primary care duties because of the relative dearth of widespread primary care availability in Idaho. Idaho is 48 in the number of primary care physicians per 100,000 population and 49th in total number of physicians. That statistic in itself is argument for exploring one of these directions that are being discussed. Idaho is #8 in retaining graduates even though the numbers are small mostly because it is a great place to live and practice medicine. Most folks settle near where they train and most physicians that practice in Idaho graduated from UW.

A urology practice would work best if primary care doctors take care of general urology and refer out the complex cases. That is what works best, but currently the biggest part of a urology practice is taking care of general urology and that will become more acute as the number of urology doctors constrict and the number of patients that need them expand. The AMA predicts that there will be a shortage of 85,000 physicians by 2020, so they are recommending that medical schools put out 3,000 more physicians each year through 2015. That is a great idea,

but Idaho does not have the scaffolding for that. There are no plans for a medical school, and no real way to work on increasing seats. That is why we are here. Idaho has 32 urologists in the state of which 9 are over the age of 60. Physicians over 60 are facing retirement age, so with that constriction, the practice of urology will need to revert to just doing complex cases and other cases would go back to the primary care doctors and that will be difficult because the primary care and physician numbers overall will constrict also. In Idaho, 20.7% of the physicians are nearing retirement, and that is a problem knowing the Medicare population will expand. The fast growth of the state affects these numbers as well and adds a special burden to this issue.

Dr. Williams explained he is new to the question of medical school versus expanding seats versus the future of medical provision in the state and as he gains more experience, recognizes the need to do something – hopefully a combination of both.

Chairman Geddes asked why, with his medical training and experience, did he choose to go to the military and ultimately into private practice. **Dr. Williams** said he started at the University of Arkansas, had student loans, figured out he needed help to pay for his education and arrived at the military option. He was on a scholarship with the Navy, which paid for the last three years of medical school. He in turn incurred several years of obligation to the Navy. He then secured a position at the National Naval Medical Center in urology which incurred more years of obligation. This was not going to be a career choice because of the lesser pay. Idaho is a very physician friendly state and that is a known fact among the national professional network organizations.

The distributive model of medical education is what Dr. Williams is most familiar with and, given the day's presentations, it sounds like that was the way ISU had tried to explain how this could work. At the University of Arkansas, the medical students and residents rotated routinely through several sites around the state to get to the patients. Part of the formula to retain graduates was the experience out in those local communities. The distributive model was a well worn track in medical education, and it also helps retain. The military track is also a well known distributive model because, especially in trauma care, the surgical residents are farmed out to trauma centers. Dr. Williams went to outside locations for trauma and pediatrics. That gave him a broad experience seeing both military and civilian patients.

Senator Bilyeu recalled a conversation with an urologist in Pocatello and he stated he could not prescribe certain medications to some of his patients because there were not clinical trials available in Idaho because we do not have a medical school and asked was indeed the case. **Dr. Williams** said that he had not had that experience. The medical research involved in the Treasure Valley is industry driven, and there are cooperative trials amongst academic entities that his practice participates in at St. Al's and St. Luke's. He has not been hurt in delivering medical care because of the lack of research capabilities with a major medical center. However, his particular specialty may not have that kind of experience because they are more involved in surgery.

Mr. Freeman pointed out that an article, *Country Medicine,* (on file at LSO) was provided to committee members courtesy of Dr. Williams. **Dr. Williams** thought the article was indicative of underserved areas in Idaho when a doctor flies to remote places to serve patients and other physicians who experience providing care in rural Idaho.

Chairman Geddes stated it is always good to see how actual activities relate to the issues that are being reviewed which are how to staff and fill positions in communities in the short and long

term. The meeting was recessed and reconvened at 1:05 p.m.

Dr. Ben Call, Pocatello Cardiology Associates, Pocatello, Idaho

Dr. Call came to this meeting at the request of President Vailas and to discuss some issues that he feels very strongly about and the discussion was from the point of view of a practicing physician with an interest in medical education and from the perspective of the state of Idaho rather than ISU. Dr. Call started practicing in Pocatello in 1985 and is the third Dr. Call practicing in Pocatello; his grandfather started practicing in 1925 and his father in 1951. Dr. Roy Call was instrumental in getting the first WWAMI contracts signed. In 1975, Dr. Ben Call wrote his undergraduate senior paper on *The Problem when Medical Schools Seek Availability for Idaho Residents* which seemed like a problem back then. Dr. Call was a WWAMI student with Ted Epperly and 18 others.

From a personal perspective, **Dr. Call** considers his practice as that of a primary cardiologist which is similar to the testimony of Dr. Williams. There are so many patients that can't find a physician that primary services are being provided by subspecialists. About 65-70 percent of his practice is Medicare. When the Medicare threshold is crossed, reimbursement changes and it is difficult to find a physician that will take Medicare patients.

The resolution that passed the Idaho Medical Association (IMA) was extensively debated and is outlined in the copy of Dr. Call's slides (on file at LSO):

1) The physicians of Idaho feel there needs to be medical education; there is a strong feeling that there are not enough physicians.
2) The immediate expansion of, and addition to, current graduate medical education programs.
3) Expansion of state funded medical school seats at UW (20 to 40) and the U of U (8 to 16) as an interim measure. This is important, a first priority, and where energy should be put.

Dr. Call distributed a copy of a brief synopsis of the MGT Medical Education Study Final Report that he prepared (on file at LSO) and read it in its entirety. The study suggested some options, but stopped short of any cost or resource analysis. This is a piece of information that helps to define the moment that is occurring right now. This study says there really is a need and it can be addressed or ignored. One option would be the status quo, but the aging physicians and the aging and growing population shows it would be irresponsible to maintain the status quo. That would ignore the health and economic implications. **Dr. Call** stated that the committee has a fiduciary responsibility to the physical and economic health of Idaho. The health of the state must be looked at in two ways, economic and fiduciary.

Dr. Call presented a scenario if Idaho were 33rd in the nation for physicians per 100,000. If there were 80 seats instead of 20 over that last 30 years and half of those remained in the state for 30 years, what would be the implications?

- 900 additional physicians in the state @ $812,000/yr each adding $730.0 million per year to the economy. An average physician employees five other people with salaries/ benefits.
- Today there would be 3,725 physicians instead of 2,825.
- There would be 261 seats per 100,000
- Would rank 33rd in the nation instead of 49th

The MGT report outlines three choices:

- Build a bricks and mortar medical school at a very high cost. This is not being seriously considered, so Dr. Call did not discuss it further.
- Expand contracts with WWAMI and the University of Utah (U of U). This is a turnkey decision – similar to renting instead of buying. It is a long term commitment for undergraduate medical education through the UW and U of U. The current cost to Idaho is about $48,000 per seat per year which comes out to about $3.8 million annually. The U of U does it for about 2/3 of the cost at $34,000 per seat per year for $1.9 million. WWAMI has many things going for it. The benefits of WWAMI are that it is a very easy program to utilize. UW is not just a big name, it is a huge name and there is an enormous amount of prestige associated with it. There are no startup fees. Some concerns are that there is no major control over costs–the cost is determined out of state and Idaho has to sign on the line. Major control over growth lies out of state. It is a real challenge to increase the number of seats.

  Who has the ability to control the strings? It is the Legislature because they have the money. With WWAMI, two Legislatures must be approached. The economic spinoff of hosting the program inside the state is not realized. Existing state resources are not fully utilized as President Vailas has portrayed. There are no economies of scale as the program grows.

- The third option is the distributive model. There have been 22 new medical schools over the last 15 years, 16 of those are distributive model medical schools. In this mode, they are hosted by one of the universities and utilize medical educational resources throughout the state in a collaborative manner and include all universities, larger communities and larger hospitals. It is the least expensive to operate because of economies of scale and existing infrastructure. It allows for the greatest control over future expenses, growth, and destiny. It only has to answer to one Governor, one Legislature, and one set of taxpayers. It is the most efficient use of existing resources and it builds equity. It would be a boon to Idaho economy for a lot of reasons:
  - Independence from other states.
  - Idaho students spend more time in Idaho.
  - Adds to Idaho's prestige.
  - Requires all parts of the state to work together.

Dr. Call gave an example using a law school where seats were contracted with an out-of-state institution -- it was one of a top ten schools in the country and the students came out well trained. Yet, the cost to the state was the ability to create and own its own program. A medical education school is no different. There are drawbacks. Start up costs, temporary loss of academic prestige for not being associated with a big name school. However, the state gains the opportunity to make a name for itself. The Liaison Committee for Medical Education (LCME) is the entity that does all the accreditation for medical schools and their guidelines are stringent to ensure high quality standards in all medical degree programs. This will require all parts of the state to work together.

How might this type of program be structured? The missions of all the universities would have to be reviewed and all statewide resources would have to be looked at, particularly at ISU because the SBOE has designated ISU with the health professions role and mission. ISU's eight year plan, which has been approved by the SBOE, includes a MD degree beginning in the 2010-2011 academic year. When hiring for ISU's current president, the SBOE asked for

applicants with experience in medical education and each of the four finalists had medical education experience.

Dr. Call proceeded to give list ISU's existing resources as it pertains to this issue. ISU has 75% of the professional degree programs of the public universities and 71% of the terminal degrees, the remainder of the state has 29%. There was further discussion about ISU inventories of faculty, administration, research, residencies, clinics, professional programs, distance learning networks, health sciences library, and space availability. This inventory demonstrates that the SBOE has been very faithful to its plan to assign public health education to ISU. There are a lot of resources at ISU and they are well developed. **Dr. Call** stated that this shows ISU is well prepared to take the lead in creating a medical degree program for Idaho.

"What might that program look like?" It would be a four year program administered by ISU involving all areas of the state. It would involve lecture series in the first two years and the second two years would be in the field working and not in classes very much. There would be 240 enrolled in the school. It would be governed through a statewide advisory council, chaired by the President of ISU, with members to include the presidents of UI, BSU and LCSC, representatives from IHA and IMA, and national ad hoc members. The delivery of education could happen anywhere and that would be up to the committee to decide. There are existing resources at ISU and UI. Years 3-4 could be completed throughout the state – anywhere there is a physician and hospital to work with.

The financial projections for this proposed plan were presented by **Dr. Call** with the following caveat: "I have agreed to present the financial analysis on behalf of ISU. I do so in full confidence in the due diligence exercised in writing the projections. If you have specific questions about them however, I will refer you to Mr. Jim Fletcher who is the Vice President of Financial Affairs. He has prior experience in management of medical school financial operations. The intent today is not to debate these numbers. However, I would like to provide them as a starting place in our discussion regarding an independent distributive model in Idaho."
Dr. Call stated that there is a designated committee to design the business plan and a very careful process was used to develop the plan looking at national benchmarks and ensuring it would be responsible and meaningful and meet the need to defend the numbers. At year zero, a one-time cash outlay would be necessary to hires start up faculty, initial facility expansion, and gets the whole program on the road. Next there would be four years of subsequent development costs incrementally developing administration, faculty, getting the program together, developing a curriculum, and putting the clinical resources together. That means there would be four years before any tuition is collected. Then the first class starts and the size of those classes would be built to 240 students over a four year period and at that point the baseline operation costs could be discussed.

Dr. Call reviewed the projected one time start up costs and the non-reimbursable operating costs for the first eight years ($11.0 million + $21.0 million). Beyond the first four years, the administrative costs are based on four classes of 60 students each for a total annual budget of $11.2 million. Hypothetically, the cost to the state, if the student pays the full tuition, is zero. If the state pays an average typical tuition of about $20,000 per student, the state would be liable for about $6.5 million of ongoing costs which is the worse case scenario. Other sources of money could come from endowment, grants, or philanthropy and so it is reasonable that the costs would not all be taxpayer money. These are just meant to be representative numbers, but they provide a point of discussion as the two programs are looked at together.

The question of accreditation by the LCME was discussed. The LCME has been charged with accrediting all US medical schools. This makes the training occur at a fairly uniform level. Dr. Call then went through the steps for accreditation and what was necessary to apply. Once a school has received pre-accreditation, it is authorized to open its doors and admit its first class of students. There are interim surveys over the next three years and during the fourth year there is a final accreditation survey and at that point the school is fully accredited. To apply, there needs to be a letter from an official in the state such as the Governor's Office or the SBOE requesting candidacy for the institution to proceed.

The role of the hospitals should include active involvement in the planning and implementation of a medical school since they will be economically impacted. The other part is residency training and there should be as many residency positions as those receiving MD degrees each year. This is critical to retaining physicians in Idaho. The reports heard earlier indicated that 47% of the physicians returned to the area where they served their residency and if both segments are in the same area, 80% remain in that state. That is a strong formula for retention.

In **Dr. Call's** opinion, Idaho does not have the resources to independently support residency programs in many needed specialties. Residency training needs large breadth that can only be supplied by a large population center. This could potentially be an evolving role for WWAMI. Dr. Call proposed that Idaho enter into a dialogue with the UW and possibly other institutions depending on interest, to explore the development of an expanded, collaborative approach to graduate medical education. Idaho should not try to do this. There could be a transition for WWAMI from undergraduate programs to graduate programs.

The objective was to show the need to establish an independent, Idaho based, four year medical degree program hosted by ISU with integral involvement of all Universities and that it is a strong financial and educational possibility.

WWAMI has done a great deal of good over the years bringing us from a point of minimal access to medical care in 1971 to a stable, predictable, very high quality program as an opportunity to accept responsibility for the training of the states own physicians. Many WWAMI students practice in Idaho and are proud of their WWAMI heritage. Dean Ramsey has been a consistent supporter of the WWAMI program and rural medicine, and the program has many strong friends throughout the state. WWAMI has expressed a willingness to expand their program and they have invested heavily in the infrastructure to support the program. Moving forward with any WWAMI program will be far easier than to launch a new, independent entity. **Dr. Call** stated that all of these factors do not lead to the conclusion that the decision to go with WWAMI is the best decision for Idaho.

There are two proposals to consider and the following are five proposed criteria that might help judge the relative merits between the two and fairly weigh the alternatives:

1) The quality of the training – ensure high quality. Although WWAMI is good, any program accredited by LCME would not be substandard.
2) Control – to what extent does Idaho have control over what is happening (i.e. expenses and expansion of the program)? The real question here is who calls the shots regarding the dollars and who holds their strings? How many sets of legislators and taxpayers must be answered to? It would be better to keep these considerations contained in Idaho.
3) Is there access to resources necessary to implement the program? Does Idaho have the resources, infrastructure, and expertise to make this happen? Can Idaho, as a state

divided into three separate parts, do a distributive model? MGT felt very strongly Idaho could do this. The only way to answer that question is with careful study. This is not a transcendental step that would be taken, it is an incremental step.

4) To what extent do the programs utilize existing state resources? Every program that shares resources with a medical education program would be strengthened. Existing resources are powerful tools to grow a program taking advantage of the economies of scale.
5) What is the return on investment? As the gatekeeper of state funds, this is very important and can be looked at in two ways: i) look at the number of medical school students that are produced per dollar; and ii) what are the spinoff economic benefits? The Legislature has a fiduciary responsibility to spend taxpayer money with prudence. The economic benefits can be measured.

UW will train outstanding physicians, but so would an Idaho medical education program. The answer lies in weighing all issues. This decision cannot be about Boise or Moscow or Pocatello; it cannot evolve into regional politics. It is not about ISU, BSU or UI. Every university has something to offer to the program. It is not about the future of WWAMI. The responsibility is to look after the health of Idaho, both economic and fiscal. Thirty years ago, WWAMI was the best thing that had ever been done. It answered questions and filled an enormous place in Idaho's history and allowed Idaho to be where it is now in the realm of medical education. It is time to move on and do something bigger and bring this in-house.

Dr. Call proposed that this committee recommend to the Legislature that $350,000 or some portion thereof be allocated to make Application for Candidacy to LCME to investigate the creation of an independent Idaho distributive medical education program administered through ISU and thereby seek to answer the question: *Is the establishment of an independent Idaho distributive medical education program realistic and desirable considering the resources available throughout the state?*

Chairman Geddes called for questions.

Representative Rusche had a concern about the graduates of this distributive medical school if there is not a strong tie to an Idaho rural based training program or the culture is not there that WWAMI has in selecting and directing students into primary care specialties. **Dr. Call** said it probably wouldn't work -- that all has to be in the design.

Chairman Geddes directed a question to either President Terrell or Secretary Thilo regarding one of the slides which said that ISU's eight year plan approved by the SBOE includes medical degrees beginning in 2010-2011 academic year. If that is the case, are we on track? Is that an accurate statement presented by Dr. Call? **Mrs. Thilo** stated that, yes, it is on the eight year plan. It isn't a guarantee. All the institutions can place programs as they forecast needs according to their mission, according to the service area, and what they might see in the coming years as being placed for official approval. Putting it on the eight year plan is the first step, and from there it has to go through a process called notice of intent with all the other institutions and then there is a thorough evaluation and report prepared before it is finally. Being on the eight year plan is one step of the approval, not the final step. **Chairman Geddes** followed up, asking when the MD degree was put on ISU's eight year plan, was there discussion as to which university would be most likely to be capable and able to follow through with that proposal? **Mrs. Thilo** responded that anything placed on the eight year plan has to be in line with the mission of each of the schools and, indeed, ISU has the health professions mission much like the UI has the medical education mission. **Chairman Geddes** stated that he was on the screening

committee for ISU's current president and that they did put high regard in the SBOE's request to identify potential candidates that could bring Idaho a medical school in the future.

President Terrell stated that there is a difference of opinion about whether ISU presidential candidates were evaluated in terms of their medical education background or experience. The SBOE is trying to find the answer. People who were present at that time say that no, that wasn't the direction. However, the SBOE is digging into it deeper and going back to the people who were actually on the committee. President Terrell said it wasn't necessarily what the SBOE thought, but that doesn't mean that the two SBOE members that were in charge didn't put that as part of the criteria and they are trying to find that criteria right now. **Chairman Geddes** said his experience was, it was certainly the case that those two SBOE members had represented to the committee that was the emphasis. Chairman Geddes stated the fact that each of the four finalists were directed to have very high skill and medical credentials speaks for itself. **President Terrell stated they will find out and get that information back**. The two SBOE members that happened to be in charge of that hiring of that Presidency are no longer on the SBOE so they have to find the documents that say what was the criteria for hiring the President for ISU.

Speaker Newcomb stated that it was his understanding that the mission statement for health sciences is for ISU, BSU is public policy, and medical education is UI as directed by the SBOE, so can two members of the SBOE change that mission by action of another committee they sit on without action of the full SBOE? **President Terrell** responded that the answer was no, and that is why the SBOE is trying to find out what the criteria and qualifications were.

Mrs. Thilo said they had the engagement letter. When a president is hired, what happens during the search process and what appears and is approved and validated by the SBOE and the engagement letter is the more important document.

President Terrell stated that originally he thought there was no hurry because the issue had just been brought up in a conversation, but now the assertion has been put in writing and the SBOE has to know.

Senator Davis, referring to the institutions' roles and missions, stated that the characterization that the UI has the statewide responsibility for undergraduate medical education is a major over-representation of the language from the SBOE and it has been thrown about over the last several meetings such that it has become framed as reality. The SBOE has the right to change it, but it doesn't say that, it says "regional". ["The University of Idaho … is also responsible for regional medical and veterinary medical education programs in which the state of Idaho participates." -Editor] Senator Davis stated that it is intellectually inconsistent for the SBOE to approve a specific plan of ISU to do "X", and then tell the committee the SBOE never really meant "X". Senator Davis was very disappointed in the process so far because all he sees is the universities fighting amongst themselves for territories and a SBOE who is willing to facilitate it. Senator Davis said he cares about two principal things: 1) providing a solid resource of physicians to help Idahoans, and 2) to find a solid educational model so that Idaho's kids who are qualified, who want to go to medical school and can't get into medical school have the opportunity to go to medical school. The role and mission language can be twisted any number of ways, but his sense of the SBOE and the two members on the committee is that they were more committed to not helping to hit that target at least as much as he wants to hit that target. Senator Davis stated that to say that the UI has the statewide mission is inconsistent with the history and the mission. The SBOE has the right to change that language, and Senator Davis did not like the idea that the committee may take action inconsistent with SBOE authority.

President Terrell said he would need to see the language in question. He would have liked to talk to Senator Davis about this before arguing about it in a public meeting. The SBOE has felt the same thing that Senator Davis struggled with. President Terrell has had some serious discussions with all three presidents about this issue starting two years ago. The SBOE has tried to control them. Sometimes the presidents don't listen and sometimes they don't like what the SBOE says, but that doesn't mean the SBOE agrees with them or disagrees with them nor does the SBOE want to go anywhere the institutions want to go. Whether the SBOE has the right or doesn't have the right, the fact is it was probably done and somebody thought it was the right thing to do. President Terrell didn't know at the moment because he hadn't seen the document Senator Davis was referring to. President Terrell disputed the assertion that the SBOE is holding up the process or letting presidents hold up the process. To say the SBOE is not on the same page or looking at the same target as Senator Davis, is wrong because the SBOE is looking at what is best and when they finish their study and the Legislature finishes its study and the Governor gets finished with his study, hopefully all three will come up with something we can live with. In fact, the WWAMI presentation earlier in the day is exactly what the SBOE has asked WWAMI to do for the future. President Terrell stated that he has taken heat from not only from presidents, but also legislators who hear from institutional presidents who may or may not agree with what he says. The Legislature and the SBOE have to work together. They have work together in this process. This is not a separate issue, this is not going to be up to this committee, this is going to be a combined effort of the three committees, the Governor's Office, the Legislature and the SBOE putting together something that is going to work for the State of Idaho.

Senator Davis responded that he knows President Terrell's heart is in the right place. Senator Davis stated that he wanted the committee to start functioning parallel with the SBOE. **President Terrell** replied the SBOE and the Legislature are paralleling. President Terrell doesn't just dismiss everything that President Vailas is doing, the SBOE has it processes, and medical education is not exception. The process may not be as fast as President Vailas would like to have it, but it is something that has to be worked into because Senator Cameron and Representative Bell do not have the ability to give them any money or even any WWAMI seats this year. This concept can only start when the funds are available to make it happen. WWAMI has expressed a willingness to work with the SBOE and told President Terrell that they are willing to help put together a program that will align to where the State of Idaho should be in 15-20 years. President Terrell would like to discuss this issue [role and mission] with Senator Davis because it blind-sided him and he doesn't have an answer, but he will have one. **Senator Davis** apologized that President Terrell felt blindsided by the language from the SBOE's policy, but it has been over represented by some as to what it actually says and Senator Davis just asked to get that set straight and move forward.

Chairman Geddes said that those around the table know that the seats on the SBOE are occupied for a short time by those members who are moved to donate and provide that service; much like the position those in the Legislature hold. Those are important and significant seats but we also understand that they are very temporary. But, something so fundamental as the Institutional Role and Missions of each university seems like that is something that should be very thoroughly understood and known and that there should not be an opportunity to interpret that language differently from one institution or another and quite honestly, Chairman Geddes feels a little bit sorry if that is the case, for three presidents in this state to try to fulfill their mission and their responsibilities not knowing that their supervisors, their SBOE that hires or fires them, understand what it is they are supposed to accomplish.

President Terrell said he will know on Monday.

Chairman Geddes stated that was very, very crucial and it may not be soon enough.

Mrs. Thilo thought that, to a certain extent, there perhaps needed to be clarification or definition. The statewide health professions mission of ISU is quite clear -- there is pharmacy, dental, all those programs. But the regional medical education mission for UI, that is not regional in terms of Moscow, Coeur d' Alene, that's regional medical education. **Senator Davis** found it difficult to believe that the SBOE commissioned any Idaho university to be responsible for education in Washington, Oregon and Montana. Such a statement is difficult to believe specifically in light of ISU's eight year plan to start the first group of students through a medical degree program by 2010. He thought that argument was not very defensible, and the fact that it was made troubled him about how she was approaching the committee assignment. He would rather take the approach heard from Milford Terrell, and that is the healthier approach. **Mrs. Thilo** asked to please not have her interest in this process misunderstood. Her role was as liaison and she appreciated the opportunity to sit in on this meeting because it would make her more informed when she goes to the SBOE medical education meeting. Mrs. Thilo stated that she cares about two things: 1) medical education access, and 2) about the physician shortage and it is also understood that there are limitations that need to be taken into account how to solve those problems in the short term and in the long term. She is open minded to the solution, but if every definition is not known, so be it, she will do the best she can but understand that her motives are pure.

Chairman Geddes emphasized that this was an important discussion and that clarification was needed -- perhaps the committee was several months slow in making it.

Speaker Newcomb remarked that his brother was very much involved in the WWAMI program and for as long as he could remember, he has been told about the mission roles of each university. However, he never sat down and read the SBOE policy. In fairness to the SBOE, that has been the understanding of the role and mission statement of each university and that is assumed by the universities themselves. There is the exception to the rule by two members of the SBOE that sat on the committee when Dr. Vailas was hired and that is, to say the least, very remiss. It needs clarification, was there official action by the SBOE to change the mission or was there ever an action by the SBOE to define the mission?

Chairman Geddes said the SBOE's Institutional Role and Missions is the defining document (http://www.boardofed.idaho.gov/policies/r_m.asp), but what has happened is that over the years it has been taken for granted that people always tell the truth. The words mean what they say, but people's interpretation of those words can be very far reaching and different.

President Terrell was very confident that he did know the meaning of "regional" in that statement, and that the confusion is that words "region" and "regional" are used almost in the same sentence referring to something entirely different. The only regional medical education program the state has ever participated in is WWAMI, so that is the "regional" medical education program it refers to. The word "region" in the preceding sentence refers to North Idaho.

Chairman Geddes stated that if President Terrell's interpretation is correct, he found it disconcerting that ISU also had a medical degree program on its SBOE-approved eight year plan.

Senator Cameron said that that the language still doesn't say that UI has the role and mission

for undergraduate medical education, but that is what it is portrayed as their role. **President Terrell** reiterated that what the language refers to is WWAMI.

President Vailas stated that he would like to say that when he interviewed for his current position, he, along with the other presidential candidates, was bombarded with questions about medical education. **Chairman Geddes** asked if that line of questioning continued after President Vailas had advanced from the screening committee to the final interviews with the SBOE. **President Vailas** stated that was correct. However, that wasn't the only reason he was hired. The other thing is that doctors are health professionals and they have accredited programs including medical residents. We have never been, as an institution, given any resistance by the SBOE, but actually got their full support, to continue on that track for not only medicine, but other disciplines. These are all professional degrees. What is important is that to offer any of these degrees, there must be all of the infrastructure and the institution must be very committed to the entire education process. Under that premise and as a potential incoming president, the biggest attraction to President Vailas, was the challenge to continue building on the degrees and investment by the state. The health professions are what they are, but there is a lot more to giving a degree than just teaching.

Dr. Jonathan Cree, Director, ISU Family Medicine Residency

Dr. Cree related that he was from England and trained at Oxford University. Oxford has been sending its undergraduates to different medical sites for a century. They have been using the distributive model and their hospital is a small cottage hospital that can only train 20 graduates and the other 100 students in his class were sent around England. This can be done. There are models for this and he would encourage Idaho to look at this model.

Residents are doctors, these aren't students, they are paid and they work 70-80 hours a week and they do this for three years. **Dr. Cree** had a handout, *Idaho State University Family Medicine Residency Program* (on file at LSO) that had the history, recruitment information, funding, expansion, and retention for the ISU family medicine residency program. The committee would be hearing about residency programs in family medicine, psychiatry and internal medicine, but nothing on surgery, obstetrics, medicine sub-specialties, anesthesia, orthopedics, or pediatrics, and that is the problem if a medical school is to be started. A partner will be needed to start those residency programs in a medical school that currently exists for accreditation purposes.

Dr. Cree explained that his department is more than a residency program; it is less than a department of medicine in a medical school. The education section houses a residency program in family medicine and in pharmacy providing clinical education training to 16 different kinds of health professionals who come from ISU. There is a research division that is very active and brings in NIH grants. The patient services division has a quality Medicare area and there is a medical technology division that has an information degree. These are things that are not usually done by a residency program and make this department a little more expensive for the state. The study program is very complex; there are 16 specialties a physician is involved in with primary care. The residency goals are service to patients and the recruitment and education of family physicians.

Dr. Cree provided some history of the ISU Family Medicine Department and Residency area from 1992 to 2009. The program will be restructuring to become a community health center. The ISU program is different from the Boise program. Some of the university departments that interact with family medicine are those such as history, music, physics, library science, media and business. The availability of these outside departments is one of the benefits of a university

setting. **Dr. Cree** further elaborated on areas of training in the health professions. The family medicine program maintains a total department staff of 80 with an addition 104 volunteer faculty members. Expansion of the residency program would create the need for more faculty. There must be one faculty member for every six residents in addition to the director. The infrastructure becomes more expensive as the program gets larger but there are some efficiencies of scale.

All the residency programs talk about service. Family Medicine provides $1.1 million of unreimbursed care which is money the program does not get back and it involves visits to nursing homes, prisons, free clinics, juvenile detention center and hospice. The program is one of the providers that accept Medicare in Pocatello because private physicians cannot afford to do it. The program gets $770,000 from the state, so given the $1.1 million unreimbursed care, the state is benefitting.

Residency applicants who are also Idaho residents are given preference because they are more likely to stay in Idaho. There are six positions available each year. The residency match rate is pretty good given the isolated geographical area.

Residency programs aim at having between 50-55 percent of their budget coming from clinical revenues. ISU is at 53% and will try to increase this amount by becoming a community health center. The three pillars of the revenues are: clinical at $3.8 million, state $757,900 and GME at $874,500. The hospital portion of the budget ($116,600) is tiny for residency programs -- it should be around $700,000 - $800,000. Medicare GME has plateaued, so the income will not have a future increase. Clinical revenues are increasing, and the Residency will try to increase it further. Grants are important and the Residency work very hard to get them. There are some federal grants (UPL) and those dollars are pending.

Both residency programs were asked how they could expand over the next four years. ISU has a fairly conservative plan, which will be reviewed by JFAC as part of the budget process. The plan is to increase by two residents for 2009 to 20, another two in 2010, one in 2011, and one in 2012 for a total of 24 with three on a rural training track in Rexburg. If the state supports the increase, it may be possible to go to 27, because Rexburg is growing so fast they may be able to take two a year. Looking at the Idaho map, 2008 shows programs in Boise, Caldwell and Pocatello; Magic Valley should be up and running in 2009; Rexburg in 2010. What about Coeur d Alene, Moscow, and Lewiston, who will decide how they will be funded, will there be a committee, should the hospitals take responsibility for it? These are questions to be answered for more expansion.

Regarding retention, Idaho is #8 in the nation; 65 graduates in 2008; 33 graduates settled in Idaho and 35 family practice graduates are in the rural areas.

All parts of the chain must be on board with the program. Idaho has scarce resources and the state can't afford to let go of what has been achieved at the UI. The residency programs collaborate with each other. All of the resources are scarce and the universities have to get together to use the resources that are available if there is to be a medical school and continue graduate medical education. **Dr. Cree** pledges to continue on a collaborative path while chairing the ISU Department of Family Medicine.

Dr. Ted Epperly, Program Director and C.E.O., Family Medicine Residency of Idaho

Dr. Epperly opened with a strong support statement for Dr. Cree and the program he administers. The WWAMI program has produced some really good people and got them back to Idaho. It is about investment in people and the efforts to create something for our state. **Dr.**

Epperly enjoyed the tension and energy around the earlier discussion. From his observations, it speaks to how important of an issue this is. He is glad to see the Legislature, the SBOE, the Governor, and the citizens of this state engage in a debate of this magnitude with this degree of passion because it is important.

Dr. Epperly showed, from a family medicine perspective, what the Family Medicine Residency of Idaho (FMRI) has done for the state in 34 years. The key piece of what this program does is to take students out of medical schools all across the country and train them to be outstanding physicians. It takes a three year program for family medicine to do that.

The Family Medicine Residency of Idaho (FMRI) has been in existence since 1975 and came together because the people of southwestern Idaho perceived a need to train family physicians for the health care needs of not only these counties but this state. The current process is the same except on a grander scale for a medical school. The pipeline from this one program has produced 221 graduated residents and 124 of those have remained in Idaho (56%) and 46% serve in underserved and rural Idaho. Investment in FMRI's future family medicine expansion will help continue to build the infrastructure that Idaho must have. **Dr. Epperly** calculated that these 221 graduates have collectively seen over 16.1 million patient visits. It is absolutely critical to the state of Idaho that these programs thrive and grow more to get the sorts of care Idaho needs. The mission of FMRI is three-fold:

- Train superb graduates to become outstanding family physicians. They are family physicians, still see patients, still deliver babies, still work in hospitals but also invest in training people.
- Retain these people in Idaho, particularly in rural Idaho.
- The focus is on the underserved. FMRI is the safety net provider for Ada County. There are more patients than can be handled including those coming from 29 foreign countries. Many immigrants, uninsured, Medicare, and Medicaid patients are seen. Good education is good patient care, the two can coexist.

Statistics show FMRI has 46,000 patient visits/yr., 900 medical admissions/yr, 1000 OB deliveries/yr, 2000 pediatric/newborn care/yr and 20,000 in-patient visits/yr. It is not cheap to train a resident. The rough cost just for expenses per resident is about $70,000. This does not include the faculty supervision, the indirect costs, or the administration of the program. The resident salaries are not robust, $44,808/yr for a 70-80 hours work week. The ACGME, which oversees the residency programs, mandated that they can't work more than 80 hours a week averaged over four weeks. It takes a great deal of work to supervise the residents so they will do good clinical work on the patients. The cost of the program in FY 2008 is about $10.5 million/year. In FY 2009, it will be $11.8 million. In looking at the revenue streams, about 50% comes from patient revenues. If the program is driven harder it borders into the slave shop. Education is the primary goal – training doctors for the future. Both hospitals (Saint Als and St. Luke's) contribute (12% and 13%), and most of that money is through Medicare money they get specifically for graduate medical care education. This money is in jeopardy, it is in danger based on the economy and restructuring of Medicare. Grants produce 9%, state of Idaho 8%, and some other miscellaneous revenue. The state funds are contributed to the support of the resident at $32,000/yr/res. Nationally the average is $70,000. The total cost to train a resident is $125,000. FMRI is asking the state for about $34,000 per resident.

The funding requests for FY09-10 through FY11-12 were discussed.

GME is the best way to get people to practice in the state. The data is clear, if you want physicians for Idaho, train them in Idaho. This is the best way to retain physicians. Family

practice is essential to Idaho because it is rural, and physicians can be dispersed to small places. It is a great module of care when coupled with a physician assistant or nurse practitioner. Recruiting is very expensive. Training physicians in Idaho means they are already licensed in Idaho. They must have licenses after the first year of training.

FMRI is expanding the size of the Boise program, adding additional rural training tracks and developing fellowships for and around family medicine. FMRI is hoping to expand its Boise program from a 10/10/10 to a 12/12/12 by 2010. Adding rural training tracks (RTTs) will get people outside of Boise and get them into other places. RTTs expands those physicians and it helps them see rural Idaho and for rural Idaho to retain them. A health profession shortage area is defined as having a primary care provider in the ratio of < 1/3500 people. Just from two programs, Boise and Pocatello, FMRI has been able to help Idaho get physician into those critical areas.

Fellowships are an additional year of training after the residency, so it is an optional fourth year. There is already one fellowship in sports medicine. All of these programs are accredited for the full maximum five years from the Residency Review Committees. The family medicine residencies take care of all the AIDS patients in these areas (there are 400+ in Boise, 100+ in Pocatello), and provide outstanding care to these folks. Other fellowships that would be beneficial are obstetrics, geriatric/palliative care, and rural family medicine and even a workforce center that focuses in on rural Idaho.

Dr. Epperly talked about the graduates who are still practicing in Idaho. They were all trained to remain in Idaho. This gives you a sense of what FMRI is all about, training people. It has been a good investment for Idaho. **Dr. Epperly** returned to Idaho after 21 years in the Army as a family doctor specifically to help with training residents within the state. It means a lot to get them out into the state.

President Vailas asked what the retention of fellows is and how much does it cost to train a fellow. **Dr. Epperly** answered that the training of a fellow is about the same as it was for residents, $70,000 for a resident and $75,000 for a fellow. The only difference in costs is the $5,000 more that is paid to a fellow so for the fourth year they make about $50,000. The retention rate for fellows is at 80%.

Dr. Larry Dewey, Chief, Psychiatry and Clinical Director of Mental Health Services, Boise VA

Dr. Dewey's program started because of the generosity of a number of institutions in 2006. The handout (on file at LSO) gives a summary of the history, structure of the program, recruiting information, funding statistics, the potential for expansion, and retention.

This is a very small psychiatry residency. Looking at the physician groups that make the least money, family practitioners are one of them. The second one is psychiatrists. Idaho is desperately underserved in psychiatry. The national average for psychiatrists is 14/100,000, Idaho's average is six. The majority of the counties in the US are underserved according to Health and Human Services. Every county in Idaho is a health shortage area for mental health and psychiatrists, including Ada County. Idaho has the highest rate in suicides in the US and there is a very high level of serious mental illness. Idaho does not spend very much per capita for services – generally at the bottom in US ratings.

In 2006, the Department of Veterans Affairs expanded graduate funding and at the same time St. Luke's and St. Al's contributed to the funding and the Legislature agreed to fund 10% of the

residency. This residency generates no revenue and so all costs are born by the sponsors. The people that are treated often have no basis of income, they have no jobs, no insurance, and they come through a public entity.

Senator Davis asked whether his understanding was correct that the federal bailout of the banks included a mental health financing component, and if so would that help with financing for the VA? **Dr. Dewey** responded that there was a mental health parity provision in the law, and it may be, because of that law, insurance programs are going to be required to cover mental health conditions at the same level they cover regular medical conditions and that may help the residency. **Senator Davis** asked if those states that have gone with the mental health parity component previous to the new federal mandate could also benefit. **Dr. Dewey** did not know the answer to that question.

Dr. Dewey said it is very difficult to start up a residency. The reason why his residency program is function is because they followed a model that allowed the residency to piggy-back entirely on the strength of the UW graduate medical education programs. This allows for the recruitment of high quality candidates for the program, and gives Idaho the opportunity to train the residents and hopefully get them to stay in Idaho. This program was modeled after the psychiatry residency program in Spokane, and they have been able to keep more than 50% of their residents in the Spokane area.

President Vailas asked if there are plans to utilize the state hospital in Blackfoot as a training site. **Dr. Dewey** said they have been trying to sign an agreement with Portneuf Medical Center to have a resident spend part of their fourth year in the Pocatello/Blackfoot area, so the intent is to do that and it is hoped that plan will be successful. It would be good for the residents to be exposed to the state hospital in Blackfoot and also other communities outside the Treasure Valley. As part of the requirements of the residency, two months of the fourth year of residency will be spent outside the Treasure Valley area which will be an opportunity to find places where they can practice.

Dr. Scott Smith, Internist, Boise VA

Dr. Scott told the committee that the VA internal medicine program was started in 1977 and was one of the first primary care medicine tracks in the country -- a new Medicare funding opportunity that was available at the time. The program has six interns doing one year of internal medicine before something else like urology, radiology, etc. There are ten second year residents that spend their first and third years of residency in Seattle and come to Boise VA for the second year. Internal medicine is different from family medicine in a couple of ways: 1) the residents have the opportunity to go into fellowships that are three-five year fellowships, 2) broad exposure to subspecialties is mandated.

There have been 203 graduates of the program since 1977 of which 63 (31%) practice internal medicine or a sub-specialty in Idaho and 144 (71%) practice in the WWAMI region. The residents are getting only one year exposure in Idaho, so if the program was expanded to two years, it would be expected that the retention would increase to at least a 50% retention rate. Until recently, the funding of the program has been totally by the VA (about $2.0 million), and about $1.0 million shifted costs that are donated by the faculty (their salaries are paid for doing other things but they are teaching instead). St. Luke's has helped in the last two years in the amount of $85,000 for an unrestricted educational fund. The program includes a required community-based training component program wherein residents go into one of the community practices for a month to experience what practice somewhere in Idaho is like and hopefully attract them to those areas. St. Luke's contributes to the salaries as this activity occurs. There

are discussions of expansion with both St. Luke's and St. Al's from the current model which is essentially a 0/10/0 to a 10/10/10 model. Half of the first year would be spent in Seattle and the next 2 ½ years would be spent in the Boise area. It is critical for the VA to maintain the Seattle connection. Others residency programs do not match well with this program.

Speaker Newcomb asked if there was a way the state could enhance the residency programs at the VA. **Dr. Smith** stated that wasn't possible because it is an entirely federal program at this time. However, as the expansion occurs with more involvement by the hospitals, it is likely the VA will come seeking funding, because the VA will not pay for the expansion. **Dr. Smith** emphasized that the business as usual model is obsolete because the number of applicants for internal medicine residency programs has dropped.

Co-Chair Bell asked if the VA trained internists have an obligation to serve upon completion of the program. **Dr. Smith** said there is no obligation to serve. The VA realized that the quality of care as a training facility is different than the quality of care in the military and they want as many facilities to participate as possible.

Co-Chair Bell stated that the time had come to make some kind of decision for a report from this committee since there will probably be no more meetings of the committee before the session starts.

Senator Cameron followed up a little on the role of the SBOE and asked a question directed to President Terrell. If the committee were to move forward, an application has to be sent to LCME, as he understands it. He has been told that the SBOE requested ISU to provide LCME with a draft of its business plan. President Terrell was asked to tell the committee what the SBOE action was and what the intentions were. **President Terrell** responded that at the last SBOE medical education meeting (October 14, 2008), Mr. Jim Fletcher, Vice President of Finance & Administration, presented ISU's business model. Afterwards, Senator John Goedde asked Mr. Fletcher if he could have the business plan sent to LCME for an independent validation of the proposed startup and operating budget. That was done on November 10, 2008, and the SBOE expected a response within just a few days. LCME told SBOE they would have some answers before November 18th, so that leads into the next stage of what will happen and what questions LCME have for ISU for the future. This was not a SBOE action – they just facilitated the information request on behalf of Senator Goedde.

Senator Cameron stated he was concerned that this whole issue has become polarized and the SBOE is equally as polarized. He was also concerned that information was sent to LCME that perhaps hadn't been finely tuned, and sends a perception that the state, or this committee, is headed in that direction and somehow we have gotten ahead of ourselves. He was troubled that this action may prejudice the state's ability to achieve accreditation down the road should the state decide to seek it. He was concerned that this action was premature and harmful. Senator Cameron asked if this review by LMCM constitutes an official action. Is it going to harm any ability should the state decide to proceed to achieve accreditation or is it going to be a black mark against accreditation?

President Terrell stated the answer is no. He spoke with Mike Rush and LCME, and they assured us that this was an informal preliminary review and they would be glad to look at it to help out. The LCME is not out there to try and kill anything that comes before them. As far as the fine tuning goes, President Terrell spoke with President Vailas on Friday, November 7th because the information was supposed to be sent and he said he needed to fine tune it and he needed until Monday, November 10th. ISU was given this extension to fine tune their proposal

and put it together. So, no, this review would not prejudice the Idaho's chances, and LCME was glad to receive it to help the state out as it go into this process. This is only a beginning and LCME will write back and provide information as to what they see as problematic or the things that the state needs to change or look at. The LCME was very user friendly and very excited to help out.

Chairman Geddes said he recalled when the LCME presented at the September 15th meeting it was represented that in order for state to submit an application there was an initial fee that we had to provide to go through that process. Did the state pay that fee to get LCME's review?

President Terrell said no, that the fee LCME referred to in its presentation at the September meeting is when an institution submits a formal application for accreditation.

President Vailas interjected that LCME requires an application fee. The review that was being done at the request of Senator Goedde was an informal preliminary step and no fee was required.

Chairman Geddes said he was in northern Idaho recently and had a chance to talk with Senator Goedde and expressed his concern that we didn't want to send anything to the LCME before we were comfortable and sure that those numbers solid, and then get off to the best foot that we possibly could. Senator Goedde told Senator Geddes a little bit more about the whole story and how that request had evolved, and said there was no time frame for when the business plan had to be submitted for review. As a result, Senator Geddes was surprised when he learned it had been submitted on Monday [November 10, 2008].

President Terrell responded that Senator Geddes had never communicated these concerns to him. This is the first time he has heard that anybody was concerned about the SBOE forwarding information to LCME for review. After Mike Rush had spoken with President Terrell about sending the information, he thought it was a good idea. President Terrell though the review would help out if, in fact, the states ultimately decides to begin offering its own medical education program. The review would help ISU to put together a better proposal. The LCME was very glad to help the SBOE and thought it was a smart idea in fact to even do it. President Terrell stated that he did put a deadline on getting the response back from LCME so SBOE would have by the SBOE medical education meeting on November 18th.

Senator Davis said Milford Terrell and he are better friends than their earlier exchange may have suggested. Senator Davis apologized for not discussing the role and mission issue in private first. He and President Terrell are committed to a solid education in the state of Idaho. He stated that while he and Sue Thilo are not friends, neither are they enemies, and he did not want his earlier comments to become the basis for an adversarial relationship. He acknowledged that they basically have not had the opportunity to work together and he certainly doesn't want anything that was said or the approach taken to prevent that in the future. Senator Davis apologized. He stated that he is a graduate of "The University" and admit to the Vandal bias. He found great value in the discussions over the last several meetings. He has a series of concerns and expressed them, albeit improperly. He genuinely believes some of the concerns he expressed, but certainly could have done so in a more appropriate fashion. He expressed those sentiments on his own, based on his own conclusions and observations. He asked that no one attribute them to promptings of anyone else. Of the things he had seen and heard presented throughout the meetings, the resolution passed by the Idaho Medical Association (IMA) was the most meaningful. Senator Davis stated that the IMA's three recommendation (develop an Idaho-based four year medical education program, expand

residency programs, and fund more seats at WWAMI and U of U) are the fundamental building blocks of what should come out of the interim committee.

Senator Davis moved to adopt the three-prong approach for expanding medical education in Idaho as the resolution adopted by the Idaho Medical Association sets forth:

(1) Development of an Idaho-based four-year medical education program.
(2) Expansion of, and addition to, current graduate medical education programs to include family medicine, internal medicine, psychiatry, pediatrics, surgery, and obstetrics/gynecology.
(3) Expansion of state funded medical school seats at University of Washington from 20 to 40 per year and University of Utah from 8 to 16 per year as an interim measure.

Co-Chair Bell seconded the motion.

Senator Davis added that what was noticeably absent from the statement was any mention of ISU, although he finds compelling the presentation ISU made. However, he didn't believe that either the Governor's Select Committee on Health Care or the Legislature's Medical Education Interim Committee should make that kind of a decision which rightfully belongs to the SBOE. He did believe that the SBOE has said to ISU that medical education is their role and gave it specific authority and in 2010 it would begin its first class. He thought the SBOE said so when it approved the eight year plan. He stated that whatever ultimately happens has to be collaborative with the current providers of undergraduate medical education in the state of Idaho. He believed it has to include the state's universities, and hoped it would include ISU as the lead institution, but he did not believe it was appropriate for him to characterize or couch a motion that takes away from the SBOE it's independent right to do what is in the best interest of Idaho.

Senator Cameron stated he didn't disagree with most of what was said, he was struggling with how to advance the issue. If the state had money it could move forward with a business plan. Senator Cameron inquired of Senator Davis how sought the business plan being worked out? **Senator Davis** admitted his motion failed to do two things: it failed to first set a date for the first class, and it failed to address funding.

President Terrell asked that motion be a recommendation to the SBOE. That would give the SBOE a chance to look at the same things that Senator Cameron spoke of. The SBOE would have to look at start dates, and some of the things discussed earlier about their own recommendation that they are hoping to put together on November18th. He thought it would be good the motion came as a recommendation to the SBOE; if it came to the SBOE in that form it would be viewed as something that the committee had come to conclusion on and that should be expressed to the rest of the SBOE.

Senator Geddes commented that the charge of this committee, as he understands is also the charge of the SBOE's committee, is to evaluate, and also make a recommendation to the Legislature. If Senator Davis' motion passed and were adopted by the committee, the motion would be the recommendation that ultimately makes it to the Legislature. This was part of the vision some the authors of SCR 135 had, and that is why there were many ex-officio members invited to participate. Certainly hope would be that Senator Davis' motion would be taken by President Terrell and Secretary Thilo to the SBOE's committee and that the SBOE would discuss and carefully evaluate to see if they can agree to make a motion that would be at least consistent or somewhat similar to Senator Davis'.

President Terrell responded that maybe there is a second motion in the works to make this something of a recommendation to the SBOE instead of just to the Legislature. That way, when all the interested parties get to the end, they go in united. **President Terrell** couldn't speak for the Governor's Office, but he could speak for the SBOE, and he thought unity would be beneficial. He stated it is the SBOE's job to sell the recommendation and clear up some of the issues discussed. When it comes time to make a decision on the expansion of medical education opportunities in Idaho, it will probably go through the SBOE, and they would be in direct contact with the JFAC co-chairs. They would all work together.

Senator Geddes said he didn't disagree with what was said. Senator Davis very carefully and artfully crafted his motion so as to circumvent the SBOE and say this is what will be acceptable to us. He stated that the Legislature doesn't necessarily always agree with the SBOE, but he did believe that it is the SBOE's prerogative to carry out their duties and to fulfill your responsibilities with respect to this issue. He expressed hope that when the Board members take the committee's action back to the SBOE committee, that the SBOE will see what the legislative committee tried to do. If there is opportunity for agreement to be reached and for the SBOE to support some sort of a resolution as well, then that would be one more step in this trilogy of committees trying to come up with the same recommendation to establish support from the governor and the rest of the Legislature to move forward on this issue.

Chairman Geddes reflected that the committee had spent three long days evaluating the needs of the state. It was his opinion that no one at the table could dispute a physician shortage in Idaho. It had been established that there is a significant need that somehow, someway, needed to be addressed in order for the medical needs of the state to be met. It had also been established that the WWAMI program is a program that has extremely high credibility and has provided tremendous value to the state in the past. However, he stated that even if WWAMI seats were doubled, it can't do everything that the state needs it to do for Idaho. There are a lot of students in the WWAMI program and the state can't pull the rug out from under them in the process of revising medical education so the state must maintain its current level of support. Another thing that has come from the meetings is how valuable the state's residency programs are and the state needs to find ways and opportunities to sustain them and enhance them. Dr. Cree said the state can't be divided. The state must be united because even in the small population of the state of Idaho there is enough experience to allow the proper training to occur. Whether training is delivered in Coeur d'Alene or Boise or Soda Springs or any other small community in the state of Idaho, the state needs to band together on this whole issue and in order for it to be a success. The final point is, since the state appropriated $300,000 to the SBOE to allow them to do a medical needs assessment, tremendous progress has been made. The issue of expanding medical education has been written about in every paper in the state, the committee has spent enormous amounts of resources and time. The busy doctors who came to present to the committee have to go home and catch up, but they did it because they see a need. What Chairman Geddes didn't want to see is the momentum fail and stop, even though the state is facing an economic crisis, the committee needed to come up with a motion that could possibly sustain that momentum so that the state can continue to make some progress. That way, when the resources do become available the state can move fast. The economy is not telling the state to slam on the brakes, but rather take some weight off the accelerator.

Representative Wood asked if there should be an amendment before the discussion.
Chairman Geddes said he couldn't make that decision.

Representative Bell spoke to the original motion. The committee's charge was to do exactly what the original motion said. It was to study, to meet, and to report back to the Legislature. That was the charge of SCR135. So, for the original motion, those were her thoughts, but a motion is always in order.

Representative Wood supported the original motion and stated that he thought he heard President Terrell say that he intended to request other presentations from other groups that might be interested in developing a four year Idaho-based medical education program and had an offer for that at no expense to the state. Representative Wood asked if the SBOE would talk about or interview for any other proposals. **President Terrell** said the things they do as a committee is then sent to the SBOE. The committee will be meeting with private enterprise to see if some of this can be privatized. There is a lot of talk about privatization. It is done at Loma Linda medical center -- one of the outstanding education schools in the US and it was a private institution that receives a lot of federal money for the medical studies they do. The SBOE had also asked for information from other people on November 18th and for help in putting together a 15-20 year plan. He though that is what committee wanted, and was possible that is what the Governor wants. This should not be a short term or fast track something where mistakes will be made.

Representative Rusche stated he had attended the IMA annual meeting as they addressed many of the same issues the committee had. The IMA resolution was the language they came up with about what they could all agree on. They all wanted to have a four year program here in Idaho and the economic benefits that come with it. However they were not sure what that model looked like. Until there is more information on the various models, the cost, benefits, what we can expect to get out of it, all they could endorse was a vision and that is what that policy statement is. Senator Davis' motion articulates the vision that was endorsed. The next step would be to assess the models and come up with the best one.

Mr. Millard brought the IHA Policy Statement on Medical Education that was adopted on October 4, 2008 to the committee. The IHA board worked on this project throughout the summer. It is the same three pronged approach that is in the IMA resolution in a little bit different order. Mr. Millard read the statement (copy on file at LSO). Today was the first time the policy statement was seen, and Mr. Millard agrees with Senator Davis, it is very compelling. However, their biggest concern is the funding because the fear is that the hospitals will be looked at to fund it. Most of the private institutions are non-profit, they don't have money where they can do a Loma Linda type of medical school, and it is not their mission. Their mission is to take care of patients. They need to participate in medical education, and they do so already.

Mrs. Thilo stated that she has a daughter going to medical school out of state, but she would have liked for her to have been able to go in Idaho. Her husband is a doctor who is going to retire next year. She cares very much about medical education and the physician shortage. **Mrs. Thilo** wanted to clarify, because it speaks to the motion, it was a good question about the eight year plan and her explanation earlier was not very good about what it is. When one of the institutions wants to add a program, they submit a request to the Council on Academic Affairs and Programs, who then makes recommendation to the SBOE. Institutions must put the program in their eight-year plan and that constitutes a preapproval for them to go further into the process to fully develop the proposal. It then comes back to the SBOE for final approval. What is happening with ISU is medical education is in their plan, and the SBOE wants it to be there, but the SBOE also wants ISU to come back after the program is fully vetted with the other institutions and with the kinds of information that this group was looking at to make sure it is a viable offering. ISU's program is in progress. Also, whatever motion passes, the time-line

needs to speak to the logistics, the cost, and the quality of the program in the near term and in the long term. When this committee forwards its recommendations to the Legislature, I would ask that a copy also be sent to the SBOE so that they can consider it.

Senator Cameron stated he didn't disagree with anything that had been said, struggling where to find the middle ground on what needs to be done. He supported Senator Davis' motion, but he wasn't sure it advanced the issue as much as he would like, so he offered a substitute motion.

A substitute motion that the committee adopt the three-prong approach for expanding medical education in Idaho as adopted by the Idaho Medical Association (Resolution 01 (08)), to wit:

(1) Development of an Idaho-based four-year medical education program.
(2) Expansion of, and addition to, current graduate medical education programs to include family medicine, internal medicine, psychiatry, pediatrics, surgery, and obstetrics/gynecology.
(3) Expansion of state funded medical school seats at University of Washington from 20 to 40 per year and University of Utah from 8 to 16 per year as an interim measure.

That the committee recommend to the State Board of Education that they also adopt this same approach.

That Idaho State University, WWAMI and any other model may, with their own resources, develop a business plan for the delivery of a four-year medical education program in Idaho.

Senator Cameron explained that the state stands at a crossroads. The state could adopt a medical education program, but can't really move forward with it without the development of a business plan. Thus, whether the state should WWAMI or embark on a four-year program at ISU cannot be answered at this point in time. There simply won't be any state funds to do anything, and it didn't make sense to commit to provide funding but then turn around and take it from somewhere else in the universities' budget. This motion would allow WWAMI and ISU to move forward if they so desire. It would not be wise to set a date at this time. **Chairman Geddes** asked if it would help to change the motion to say it would be ISU's charge to develop a plan in conjunction with WWAMI. **Senator Cameron** responded that that wasn't his intent. The intent was that ISU could move forward with the development of a business plan for their distributive model, and UI and WWAMI could develop their own business plan for the expansion of a four-year program in Idaho. There would be some opportunity for oversight by the SBOE.

Speaker Denney seconded the motion.

Representative Rusche stated that he was uncomfortable with the additions. It was directed to two specific models and did not allow for hybrid models or alternative models. The real truth will be a hybrid model. He supported the charge to the SBOE to bring it together so there would be a united front.

Senator Cameron said his motion it was not intended to be prescriptive. The objective was to offer a four-year medical education in Idaho and provide those opportunities for students. That is the mission statement. The motion was not intended to tie the SBOE's hands, but to

empower them. The thinking was that SBOE should adopt something similar that allows ISU and UI to move forward with the development of a business plan.

Representative Wood stated concern about the wording. Naming institutions, no matter who they are, in some way is going to be perceived as the Legislature making decisions, which is the purview of the SBOE. He could support the concept of recommending to the SBOE that they do something; a request for information and a request for a proposal from anybody who is interested without naming the names of institutions. The motion should just make it clear the committee is behind whoever brings out the best proposal. The SBOE is going to have to answer this question as to what "regional" means. They are going to have to define those roles more clearly so they aren't argued about in the future, and that language may push them one way or the other.

Senator Cameron understood the point, but in order for institutions to raise money and expend funds to move forward, they need some indication of support from the committee that yes, the committee is interested in moving forward and that is the intent. The motion doesn't make any guarantees or commitments. The institutions still have to come forward and demonstrate there proposal would be cost effective. There have only been two proposals on the table. This is not to discredit the opportunity for other programs.

Speaker Denney spoke in support of the motion. He stated that there is no doubt about the need for physicians, and all have been convinced that right now with the current budget, there is no money for an increase in WWAMI, there is no money for U of U seats, or even the residency program. That leaves the committee with nothing, and the substitute motion is permissive and allows ISU and/or WWAMI to come forward with a business plan and present it. They know they are not getting any money.

President Terrell assured the committee that they will have the language at the December SBOE meeting and will insure it is very clear as to what that language means.

Co-Chair Geddes called for the vote on the substitute motion.

The motion carried with 7 ayes and 1 nay. Representative Rusche obtained clarification and changed his vote to aye, changing the vote to 8 ayes and 0 nay.

Co-Chair Geddes called for a motion on the September 15th minutes.

Representative Rusche moved to approve the September 15th minutes with the spelling correction of Mr. Terrell's name. **Senator Cameron** seconded the motion. The motion carried by unanimous voice vote.

Chairman Geddes thanked the members and guests for coming and the meeting will stand adjourned at 5:00 p.m. subject to the call of both the Chair and Co-Chair.